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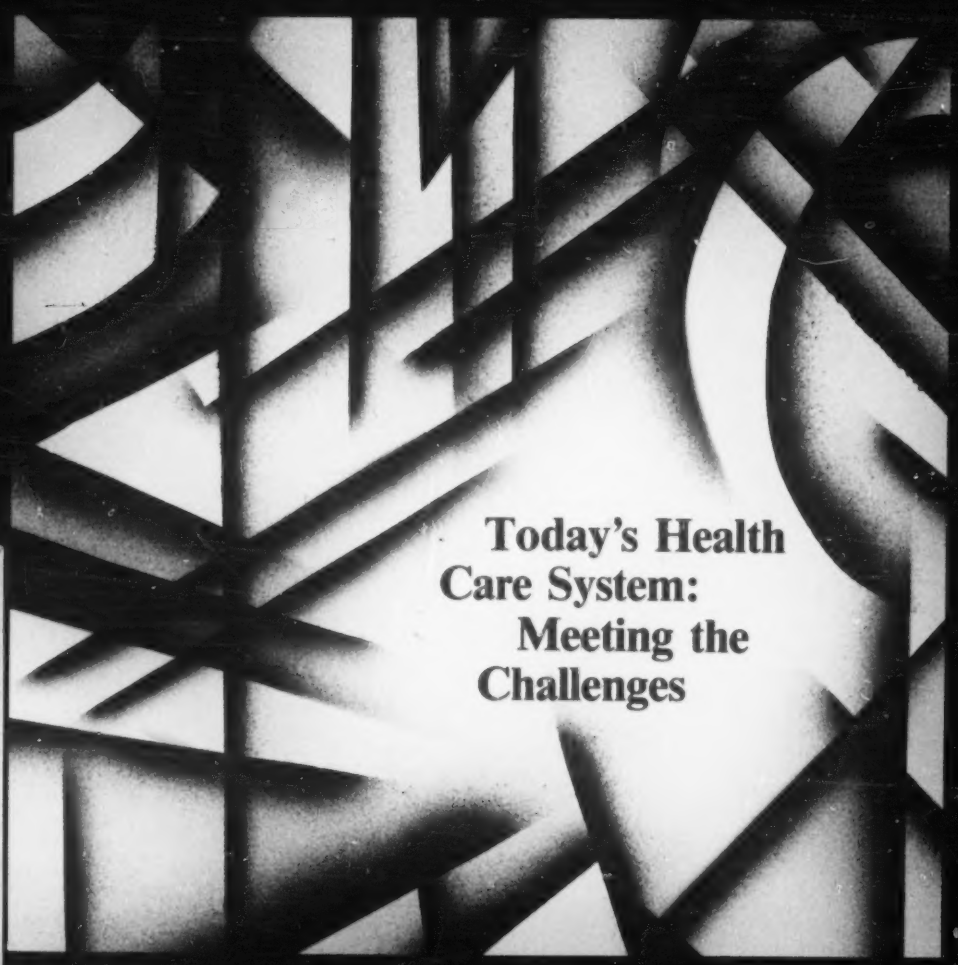

Today's Health Care System: Meeting the Challenges

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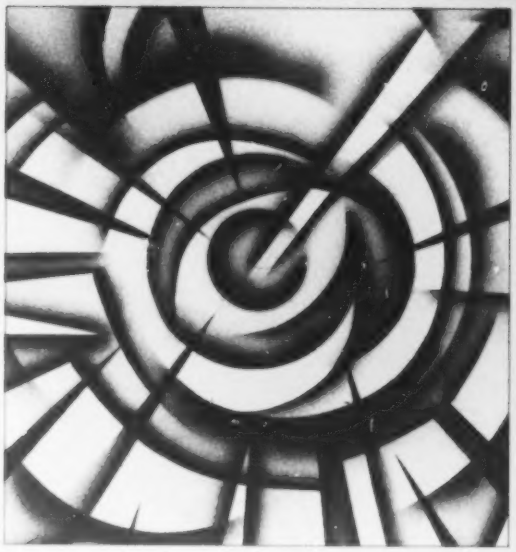

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Analysis of the Market Driven Nursing Shortage

Sr. Rosemary Donley and Sr. Mary Jean Flaherty

Donley and Flaherty look anew at the nursing shortage; they explain why the supply-side orientation cannot explain or resolve the problem. The mere increase in our numbers is not a solution in today's complex care environment. The authors explain the market-driven shortage and the changes in the work environment essential for ameliorating the shortage.

In December 1988 the Davis Commission on Nursing convened by Secretary Bowen to study the nursing shortage released its final report (Secretary's Commission on Nursing, 1988a). Other experts, from Goldmark (Winslow, 1923) to the Institute of Medicine Panel (1983), were dutifully convened, diligently employed, and were responsive in completing their work. However, their reports became part of the chronology of nursing studies—historical footnotes about a troubled profession. Old hands wonder whether the work of the Davis Commission will fare any better. Mindful of this history, the authors discuss the demand-driven elements of the shortage of the 1980s and examine the Commission's finding that conditions in the workplace are a factor in the nursing shortage.

Most students of nursing's labor market have emphasized the importance of the supply and demand equation. The Surgeon General's Report, which gave birth to the first generation of nurse training acts, saw a mandate for federal support of nurse training in the predictions of a changed health care system (National League for Nursing, 1963). As late as 1983, when the Institute of Medicine reported no shortage of bedside nurses, fluctuations in the nursing labor force were still being addressed within a supply side framework that emphasized recruiting and retaining nursing students and helping young graduates adjust in the workplace. In the present shortage, public and private efforts continue to address recruitment and retention. Recruitment initiatives have been aimed at typical nursing students: high school graduates. Men, minorities, and second careerists have been mentioned by foundations or the federal government as persons worthy of special attention. However, these groups have never been identified as mainstream candidates by faculties of nursing.

Failure to create places for new learners in an environment of declining 18-year-olds has contributed to enrollment problems in schools of nursing—what Green (1987) labels as "the problem in the nursing pipeline." Efforts to keep students in school by using loans, remedial programs, and flexible curriculums have become normative in traditional retention activities. While retention of all students requires effort, it is a truism that recruiting and retaining nontraditional students requires substantial and creative investment of human and financial resources. Successful retention programs seem to be influenced by steady financial support. They are hindered by stop-and-go federal, state, and private initiatives.

The Division of Nursing has played a major role in stimulating the nursing supply. It can be proud of its successful stewardship of nurse education funds and its good record in in-

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creasing the number of schools and the number of entering students and graduates. Even when admissions to associate and baccalaureate degree programs declined by 30% between 1983 and 1986, it was possible, using conventional supply-side wisdom and experience, for the Division of Nursing to answer political questions about the existence of a nursing shortage because graduates of RN programs reached an all-time high in 1985 when 82,075 young nurses entered the workplace (NLN, 1987).

However, close scrutiny of enrollments in nursing programs shows fewer first-year students (see Table 1). Since 1983, students in all RN programs have decreased more than 25%—from 250,000 in 1983 to fewer than 194,000 in 1986 (Landers, 1988). Preliminary data from the NLN (1987) indicate enrollments will be less than 180,000 for 1987.

But in early 1987, the traditional answer about the increase in the number of graduates failed to overcome the cries of the American Hospital Association (AHA, 1988), the largest employer of nurses, which reported an RN vacancy rate of 11.3% (which had more than doubled since 1983). In 1987, statistical reports from the federal government about the number of graduates from schools of nursing did not convince members of Congress who read not only the reports of nursing and hospital lobbies but also their local newspapers. Congressional staffs knew that while the 1987 AHA data reported regional differences, the shortage affected over 95% of urban and 74% of rural hospitals (AHA, 1988). The shortage was a public problem. The formation of the Davis Commission was prompted by the question of how to reconcile the increased number of graduates from RN programs and the RN participation in the work force in 1984 was 78.7% with the steady nurse vacancy rate reported (AHA, 1988). Hospitals reporting a severe (40%) or moderate (26%) RN shortage noted at least a 10% vacancy rate for licensed practical nurses. However, the overall vacancy rate for LPNs was 6.2% because 57% of the hospitals reported no vacancy (AHA, 1988).

It is not surprising that, given the data on the relative adequacy of the nurse supply, analysts of the 1980 shortage minimized the supply side of the equation and began to discuss demand.

Several demand theories have been advanced to explain the nursing shortage. The most common, and probably most accepted explanation, is the intensity of care thesis. This thesis espouses the belief that although fewer patients occupy hospital beds in the post-prospective care era, they require more medical and nursing care. A competitive posture in the health care system and public expectation requires investment in the expensive technology that enables sophisticated and complex diagnostic and therapeutic regimes. Because prospective payment legislation discourages the use of inpatient care, patients are admitted to hospitals only when treatments are imminent. As a result, they are sicker during their hospital experiences and are discharged before their conditions have stabilized. In 1987, 81% of hospitals reported a greater severity of illness of their patients than was reported in 1986 (AHA, 1988). Although hospital occupancy rates have declined in the post-prospective era, the demand for hospital-based acute care nurses is high because of the age of hospital patients, the complex nature of their illnesses, the use of high technology such as transplantation, and the shortening of the average length of stay. These factors support the intensity of care explanation—an inadequately defined concept that partially explains why hospitals employed 86 registered nurses per 100 patients in 1984 and 96 registered nurses per 100 patients in 1986 (Secretary's Commission on Nursing, 1988b).

> ***"The substitution of RNs for other nursing personnel created a further blurring of the work of professional nurses, contributed to the shortage, and influenced the AMA proposal to train registered care technicians."***

The changed financing in acute care hospitals has redirected care activities. People formerly admitted to inpatient settings for surgery are now day-surgery patients. Early discharge programs have increased demand for nurses in ambulatory care centers, homes, and extended care facilities. Patients in nursing homes and in home care programs are sicker because of early discharge from hospitals. Between 1981 and 1985 Medicare admissions to skilled nursing facilities increased by 23%. Registered nurse employment in Medicare-and Medicaid-certified nursing homes increased by 22% between 1981 and 1986. The average number of RNs per 100 beds increased from 5.2 to 5.7 in this period. From 1980 to 1987 Medicare home health visits made by registered nurses increased almost 60% (Secretary's Commission on Nursing, 1988b).

The expanded need for care in these settings is one factor in explaining the movement of nurses away from hospital work sites and the diminished nurse supply in acute-care hospitals. However, the changed care environments have also redirected the work of nurses in hospitals. Experienced nurses now work as discharge planners, case managers, and quality assurance experts.

Another factor in the demand equation is illustrated by the principle of substitution. Aiken and Mullinix (1987) argue that low wages make nurses attractive and versatile employees in hospitals. Nurses not only perform clinical care in hospitals, but also fill in for professional and nonprofessional workers. Any nurse who has worked in hospitals can define substitution and provide more than a few "war stories" about nurses doing the work of other health team members. Why, then, is substitution a factor in the current debate? There is some evidence that hospitals reduced their personnel budgets as an initial adjustment to prospective payment legislation. The work of nurses was expanded to encompass the work of furloughed employees who had performed clinical support functions, transportation services, and food services. The need for ancillary workers,

stimulated by high technology, the demands of labor unions, and new construction of hospital beds, have long been recognized. Their absence in the post-prospective health care system caused diminution of expected patient care services. Historically, nurses have been able to accommodate their own work loads while performing the tasks of others. The health care system of the eighties, however, is more complex. Nurses can no longer substitute for so many others.

In the eighties, the substitution of registered nurses for licensed practical nurses and aides was driven by clinical and economic forces. In the late seventies, professional support was given to the development of primary nursing practice and the recruitment of all RN staffs. This model was most popular in tertiary hospitals where RN staffs provided nursing care around the clock in critical care environments. After 1983, when levels of care increased in community and tertiary hospitals as the less sick were treated as outpatients and the still sick were sent home, all hospitals employed more registered nurses in all patient care units.

There was an economic as well as professional principle at work in the movement to an all-RN staff. The salary difference between licensed practical and registered nurses made professional nurses a bargain. Recent salary figures reported in the *American Journal of Nursing* (1988) indicate that there is approximately a $6,000 difference in mean starting salaries (RN, $20,964; LPN, $14,856) and a $9,000 spread in mean maximum salaries (RN, $29,088; LPN, $20,052). On average, a licensed practical nurse earns one-fourth less than a registered nurse, 75 cents on every dollar. In the height of the shortage, AHA data reveal that community hospitals faced with shortages hired registered nurses from agency pools and pressured permanent members of the RN nursing staff to work extra hours. Between 1983 and 1986, community hospitals reported a 25% decrease (56,000 full time equivalents) of licensed practical nurses and a 23% decrease (69,000 full time equivalents) of ancillary personnel. During this same period, these hospitals increased their employment of registered nurses by 5.5% (38,000 full time equivalents) (Secretary's Commission on Nursing, 1988b).

When the demand and price of registered nurses limited job opportunities for licensed practical nurses, enrollments fell in school of practical nursing.

The development of all RN staffs contributed to the use and demand for registered nurses. The substitution of RNs for other nursing personnel created a further blurring of the work of professional nurses, contributed to the shortage, and influenced the AMA proposal to train registered care technicians.

As the shortage of nurses continued into the fall of 1988, employers and insurers became uneasy because salary increases are always proposed during nursing shortages. *The American Journal of Nursing* (1988) reported that the so-called $40,000 solution is common in large cities such as Philadelphia. Boston's Faulkoner Hospital eliminated 77 middle management positions to underwrite a 17% raise for its staff nurses (new starting rate $26,051; new maximum salary $40,726). If registered nurses are paid significantly more than licensed practical nurses, all-RN staffs will increase hospital personnel budgets. Given the new salary scales, vice presidents for nursing and hospital administrators are less enthusiastic about all-RN staffing. When the salaries of registered nurses significantly outpace practical nurses, the RN/LPN ratio will shift.

The dramatic evolution of health care systems also contributes to demand for registered nurses. As has been noted, home care and ambulatory surgical centers have expanded greatly since 1983. More patients receive skilled care in long term settings. The need to manage care, coordinate the movement of patients through the system, and to monitor quality and cost has engaged nurses in these fields. Because enrollments and graduations have not kept pace with the developments in health care environments, new fields of practice compete with hospitals for a scarce work force.

Some insight can be given to the appeal of ambulatory and home care work sites by a closer glance at the AHA vacancy rate. Over 16% of the hospitals indicated that it took 60 or more days to recruit for "days only" positions and 53.7% found that recruitment for "nights only" positions required more than 90 days. Hospitals (46.9%) which required "rotation to all shifts" had the most difficulty filling positions; "day/evening" rotation had a shorter recruitment time than "day/night" or "evening/night" rotations. The largest number of vacancies was for "evening only" or "night only positions" (AHA, 1988), the so called hardship shifts.

The cost of nursing services affected demand in another way. For many years hospitals relied on students to perform hardship tasks. Later, new graduates worked weekends and shifts. These entry-level workers not only started at the first rung of the work ladder, they entered the labor market at the bottom of the pay scale. In periods of shortages, hospital administrators raise beginning salaries and offer bonuses to newly employed nurses. In times of severe shortage, however, raising entry-level salaries only redistributes the available work force. Some hospital administrators complain about the limited success of price wars carried out in local and national newspapers in attracting nurses to their cities and services. However, a review of salary scales reveals that raising entry-level salaries does not affect salary ranges. Wage compression is perhaps the most serious economic impediment to a career in nursing. In 1988, new graduates earned, on average, $7,000 less than nurses with 10 years of experience (Aiken & Mullinix, 1987). These salary data are not inflated by bullish responses to a diminishing market of new graduates. They represent the long-term accommodation of the industry to the school of nursing pipeline.

"Wage compression is perhaps the most serious economic impediment to a career in nursing."

The administrators who design salary, staffing, and benefit structures in acute-care hospitals (the

dominant standard setters in the health care system) presume that the nursing force is transient and inexperienced. Traditionally, the industry spent money on neophyte nurses who worked for their initial employers for several years. Hospitals showed little concern about what happened to staff nurses after a period of initial employment. Hospitals adjusted to

"Several demand theories have been advanced to explain the nursing shortage. The most common, and probably most accepted explanation, is the intensity of care thesis."

social forces that were described as marriage and child rearing; employment by another hospital; employment in other health settings; a return to school; movement along a career path to teaching, management or primary care; or a change of career. Because hospitals did not expect to retain more than a fraction of new recruits, their salary and benefit packages were oriented to new workers.

The Secretary's Commission on Nursing Interim Report (1988b) highlighted the inadequacy of this approach when women continue in the work force. The substitution of RNs for other nursing personnel created a further blurring of the work of professional nurses, contributed to the shortage, and influenced the AMA proposal to train registered care technicians. The Commission posited a relationship between poorly regarded career pathways and the lack of interest among college freshmen in the field of nursing.

The establishment of a link between the economic and professional rewards in the workplace and the presentation of nursing as a career is perhaps the most intriguing finding of the Davis Commission. As has been noted earlier, the expectation that earning power should increase with education and experience is not realized in nursing labor markets. The salary structures and fringe benefits do not recognize performance or tenure. There are no significant salary differentials for hardship shifts. Until recently, when some hospitals awarded bonuses to encourage retention based on the "frequent-flyer" programs model, the use of "the Baylor Plan" or some local accommodation to the rent-a-nurse agencies, illustrated creative scheduling arrangements in a woman's work force.

During the course of the Commission, it became apparent that administrators and the ANA bargaining units were recognizing that nurse retention is an industrial priority. It was also acknowledged that successful retention of nurses requires more than economic rewards. When the attention of employers was directed toward supply-oriented recruitment and the orientation of young graduates, little consideration was directed to the organization of the work environment or relationships in the work place. Authority, clinical decision making, staff involvement in the organization of professional practice, and relationships with physicians became important factors when the analysis focused attention on retention of registered nurses. Kramer's (1988b) second visit to the magnet hospitals—institutions recognized for their ability to attract and retain registered nurses—confirmed previous findings (Kramer, 1988a) that hospitals which recognized professional autonomy and respected the clinical competence of their nursing staffs did not experience shortages.

Any serious discussion about retention of staff nurses must concern itself with management. Nurse executives hold key information about staffing patterns, control the personal and work environment, influence the development and execution of budgets, and plan the ratio of nurses and nurse helpers. They can be significant forces in influencing the organizational climate and the work environment.

During the exploration of the work environment, the Commission requested a study of the influence of nurse managers with Boards of Trustees in acute-care hospitals (Kusserow, 1988). The rationale for this study centered on the importance of nurse executives in overcoming the nursing shortage. It also made several assumptions about power. Nurse executives with direct access to Boards of Directors could argue for more resources for nursing and address the importance of collegial relationships with the medical establishment. Positioning nurse executives among decision makers affirmed the importance of nursing within hospital organizations. Executives with access to power were more secure in their roles and more likely to experiment with new modes of practice and care delivery. It was argued that it would be foolish to recommend that staff nurses should exercise autonomy or clinical judgment if their superiors had limited power and lacked the ability to communicate with governing boards. To test the extent to which chief nursing officers participated in meetings of governing boards and prestigious board committees (finance, planning, executive, and joint conference), the Office of the Inspector General surveyed a representative sample of chief executive officers (CEOs) and chief nurse officers (CNOs) in 93 hospitals.

Although nurses in large hospitals (500+ beds) are more likely to engage in dialogues with governing boards, chief nurse officers, on average, were marginally involved in the governance of institutions. These findings support the belief that there is significant work to be done before staff nurses can participate in decision making.

The Commission (1988a) was so impressed with the importance of the work environment in addressing the nursing shortage that more than half of its 16 recommendations, listed in this text, address the reorganization of the work place.

- Health care delivery organizations should preserve the time of the nurse for the direct care of patients and families by providing adequate staffing levels for clinical and nonclinical support services.
- Health care delivery organizations should adopt innovative nurse staffing patterns that recognize and appropriately utilize the different levels of education, competence and experience among registered nurses, as well as between registered nurses, such as licensed practical nurses and

ancillary nursing personnel.

- The federal government should sponsor further research and encourage health care delivery organizations to develop and use automated information systems and other new labor-saving technologies as a means of better supporting nurses and other health professionals. Health care delivery organizations should work with researchers and manufacturers to ensure the applicability and cost-effectiveness of such information systems and technologies across all practice settings.
- Health care delivery organizations, nursing associations, and government and private health insurers should collaborate to develop and implement methods for costing, budgeting, reporting and tracking nursing resource utilization, both to enhance the management of nursing services and to assess their economic contribution to their employing organization.
- Policy-making, regulatory, and accreditation bodies that have an impact on health care at the national, state, and local levels should foster greater representation and active participation of the nursing profession in their decision-making activities.
- Employers of nurses should ensure active nurse participation in the governance, administration, and management of their organizations.

"The lack of a meaningful salary over a lifetime is a deterrent in vocational choice."

- Employers of nurses, as well as the medical profession, should recognize the appropriate clinical decision-making authority of nurses in relationship to other health care professionals, foster communication and collaboration among the health care team, and ensure that the appropriate provider delivers the necessary care. Close cooperation and mutual respect between nursing and medicine is essential.
- The nursing profession should take primary responsibility for providing immediate and sustained attention to the promotion of positive and accurate images of the profession and the work of nurses.
- The Department of Health and Human Services, private foundations, and employers of nurses should support and carry out research and demonstrations on the effects of nurse compensation, staffing patterns, decision-making authority, and career development on nurse supply and demand as well as health care cost and quality. Research should be sponsored on the relationship of health care financing and nursing practice.

This article began on a note of pessimism. Can one of the largest American industries adapt to address the needs of its work force? Can some of the private and public money paid for health services be redistributed so that physicians and institutional providers get less and nurses get more?

The analysis of the Commission suggests that the solution to the nursing shortage is not a quick-fix, but rather a sustained and systematic reexamination of the scope of nursing practice, the value of nursing to the health care system and the amount of money that individuals or groups are willing to pay for professional nursing services.

Table 1
*Annual Admission to Public and Private Basic RN Programs by Type of Program 1983–1984, 1984–1985, and 1985–1986**

Public and Private Nursing Programs	Number of Annual Admissions 1983–1984	1984–1985	1985–1986
All programs	123,824	118,224	100,791
Public	85,474	81,198	71,921
Private	38,350	37,026	28,870
Baccalaureate	39,400	39,573	34,310
Public	23,803	23,871	19,747
Private	15,597	15,702	14,563
Associate degree	66,576	63,776	56,635
Public	59,209	55,150	50,549
Private	7,367	8,626	6,086
Diploma	17,848	14,875	9,846
Public	2,462	2,177	1,625
Private	15,386	12,698	8,221

*Source: Rosenfeld, P. (1987). *Nursing student census with policy implications*. Pub. No. 19-2202, New York: NLN, p. 22.

Excludes American Samoa, Guam, Puerto Rico, and the Virgin Islands.

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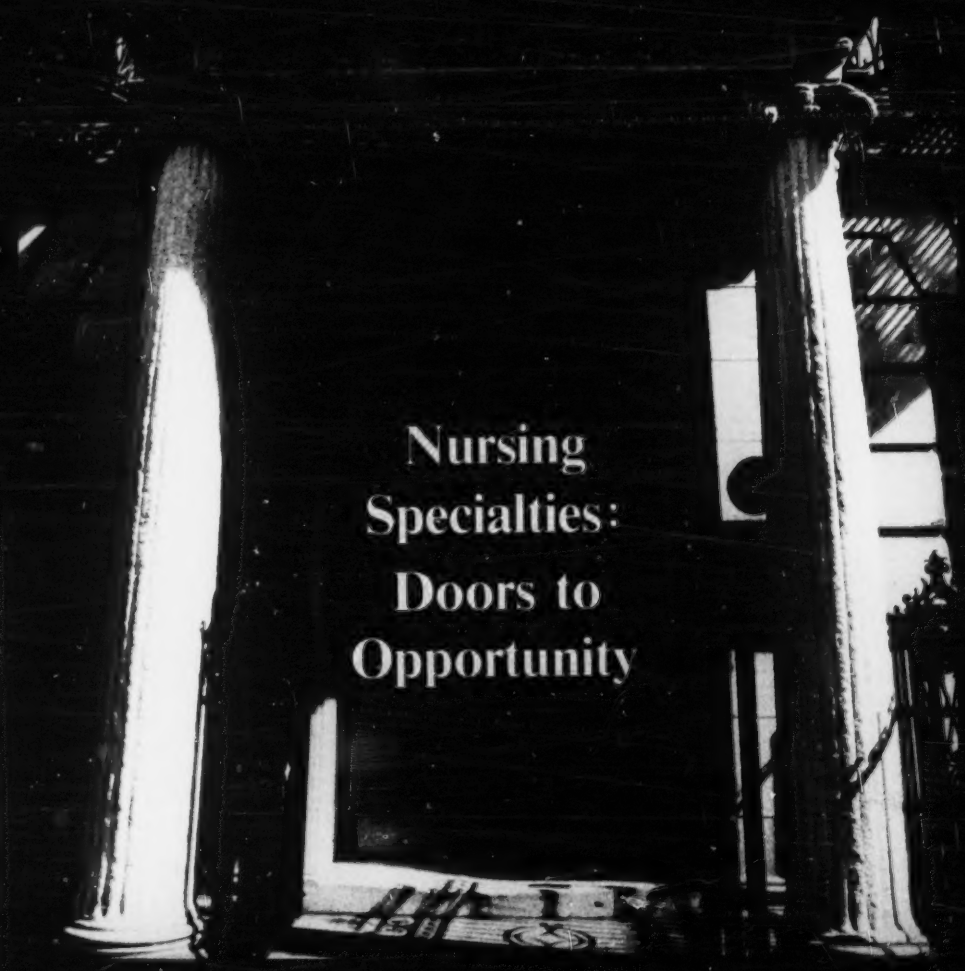

Nursing Specialties: Doors to Opportunity

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An Entrepreneurial Role for the Nurse Consultant

Sr. Mary Jean Flaherty and Dorothy DeMoya

Not all nursing specialties arise from clinical practice. Some specialties arise from the so-called functional roles. Here Flaherty and De Moya examine the nurse consultant as specialist. Furthermore, that specialty practice is looked on as an entrepreneurial role: a specialty within a specialty.

This article proposes an argument for the development of clinical specialists as external consultants. Rotkovitch (1976) proposes that the advanced preparation and skill of clinical specialists enables them to make a powerful impact on the health needs of society. Lange (1987) asserts that there is an increasing need for nurse consultants because of the technological explosion and the rapid realignment of health services in a cost-conscious society. Specialists operating within the confines of specific agencies can externalize their practices. Educators, administrators and clinical specialists can engage themselves part-time in consultative roles. In the new health care system, clinical specialists can direct care of acutely ill patients in their homes and extended care settings, design programs to prevent illnesses in schools and the workplace, enhance professional practice in multidisciplinary settings and manage complex care systems.

The historical self-image of nurses emerges as a major issue in any discussion of entrepreneurial activities. Most nurses, working in institutions, have not perceived themselves as independent practitioners with clinical skills, knowledge, and organizational ability. The unpredictable world of the entrepreneur may be an uncomfortable workplace, and role expansion may not be easy for nurses who are more familiar with bureaucratic models and defined boundaries. The impression that a transition into the competitive health world will be difficult is reinforced by a recent review of the literature.

The survey of nurse consultants

Nurses contemplating a new or expanded role as an external consultant need market-oriented information. Recently 459 consultants were asked to participate in a national survey and share their understanding, practices and beliefs about consultation.

The idea of studying nurse consultants developed during an analysis of consultation models. The survey method was selected as a strategy to elicit responses from a representative pool of nurse consultants about useful models of consultation, beliefs about consultation, and the ethical issues surrounding practice. The survey tool, developed by the investigator in consultation with a tool-development expert, was organized into four sections: Aspects of Practice, Theoretical Considerations, Ethical Considerations, and Beliefs about Consultation. Demographic data were also collected at the time of the survey.

Sr. Mary Jean Flaherty, PhD, RN, is an associate professor at The Catholic University of America School of Nursing Washington, DC and Dorothy DeMoya, RN, DNSc, is adjunct assistant professor at The Catholic University. Partial support: The Dean's Research Grant, The Catholic University of America School of Nursing, Washington, DC; 1985, 1986. The author acknowledges the contributions of Mary Terhaar, DNSc, who worked as a research assistant on this project.

A pilot instrument was sent to 50 nurse consultants randomly selected from the Journal of Nursing Administration's (JONA) Semiannual Directory of Consultants to Nursing Administration (1985). The Directory lists the following criteria to describe their roster of consultants: (a) evidence of suitable educational preparation; (b) freedom to enter consulting agreements; and (c) a fee schedule. The Directory was chosen because it represents a national listing of nurse consultants and consulting agencies that employ nurses. Forty-eight valid surveys were returned. The survey instrument was revised to address the comments of the respondents. Because the pilot group expressed overwhelming interest in the survey, the revised tool was sent to 459 consultants listed in the Directory. Four weeks later, follow-up postcard reminders were sent. Two hundred and seventy valid and 15 invalid survey tools were received for a return rate of 62%. Surveys were classed as invalid if respondents were non-nurses (N = 6) or if the forms were not completed (N = 9). Three nurses who returned uncompleted forms said that they no longer practiced as consultants, but kept the listing for tax purposes.

"The most notable finding in the demographic analysis, however, was the source of their consultation contracts: Nurses refer clients to nurse consultants."

The consultants: Demographic variables

The sample represented 252 female and 18 male nurse consultants. Their ages ranged from 28 to 71 years with a mean of 43.6 years and a median of 42 years. Family status and educational history are presented in Table 1.

On average, 9 years had elapsed since the respondents completed their formal educations. Four respondents reported graduate degrees with a major in consultation; 103 had earned credits in consultation; and 23 indicated they had taken a course in consultation in nondegree educational programs. Eighty-four percent (N = 226) listed reading as the major type of informal preparation. More than half of the respondents had formal preparation for their roles and only 11 subjects had workshop experiences.

Aspects of consultation practice

Respondents described the organization of their consultation practices. Although 63% (N = 168) of the respondents were in independent practices, only 17% (N = 45) of this group were in incorporated practices. Of those who worked in business organizations (N = 102), 52% worked in incorporated firms and 21% in partnerships. The remainder of the sample was employed in nonincorporated consulting firms. Thirty-two percent of those working in incorporated firms or partnerships were officers. Fifty-three percent of the consultants worked part-time (N = 142); 31% (N = 83) were full time consultants; 26% (N = 45) did not report their work status. Part-time consultants worked from 1 to 120 hours per week with a mean of 28 hours. Part-time consultants listed their primary employment as nursing education (24%), nursing administration (22%), and other (54%). Interestingly, clinical specialization was not identified in the broad ranging "other" category. Consultants were in practice from 1 to 30 years with a mean of 6.9 years. Fifty-six percent of the respondents decided to enter practice on their own. The remainder were encouraged by colleagues, other consultants, and family members.

Work contracts were initiated through professional relationships with other nurses (44%), non-nurses (14%), social functions (10%), presentations at professional meetings (7%), and other sources (15%). Advertisements, attendance at professional meetings, writing for professional journals, and committee work—frequently thought to provide good contacts—accounted for only 10% of the contracts (see Table 2).

Twenty-four percent (N = 66) of the consultants charged less than $50 per hour and 49% ($N$ = 133) set daily fees at $500 or less. Nine persons reported daily fees that ranged between $1,000 and $4,000. Yearly earnings from consultative practice ranged from $500 to $70,000 (see Table 3).

The profile of the responding consultants presents a cadre of midcareer professionals whose independent consultation businesses enhance and supplement their primary work and incomes. The most notable finding in the demographic analysis, however, was the source of their consultation contracts: Nurses refer clients to nurse consultants.

Financial aspects of practice were mentioned frequently in the commentaries. Respondents indicated that hospital administrators hesitated to purchase consultation services that would save them money in the future. Consultation appeared to be low on budget priority lists. In addition,

"Nurse consultants agree about the importance of fulfilling contracts and satisfying clients' interests. The high agreement by the respondents to contractual and client obligation affirms a sense of loyalty and responsibility."

nurse consultants commanded lower fees than consultants from other disciplines. The financial struggle of getting started and maintaining a consultative practice was frequently noted. The marketing of services was reported to be the most difficult task. The continuing struggles to establish practices led to frustration and an expressed need for "a network of nurse consultants throughout the country who are not afraid of losing 'turf.' "

Other issues identified by the respondents were related to preparation for consultation, opportunities for continuing education, and standards of practice. The need for educational opportunities was best described by a respondent who wrote that "post-graduate courses in consulting techniques would have saved much trial and error and 80 hour weeks to complete projects."

In many instances the respondents emphasized their professional concerns by personal anecdotes about early experiences and difficulties. One respondent found it difficult to obtain information about consultation in nursing. She rejected business information about how to get started because it was male-oriented and not applicable to her aspirations. She also reported that it took her 2 years to achieve some financial benefit from her practice.

Sixty-two percent of the respondents reported they used consultation models in their practices. This somewhat surprising finding may be explained by the data presented earlier in this paper on the number of consultants who formally studied the consultation process (N = 123). Eight consultants commented that theoretical models were not helpful.

Ethical considerations

Respondents were asked to select and rationalize their answers about contract negotiation and fulfillment. They were asked the following questions: What would you do if costs were exceeding the contract fee? What would you do if costs were running below the contract fee? What would you do if you found yourself in a situation inconsistent with your personal beliefs? What would you do if the consultee was not responding to your efforts? The responses are summarized in Table 4.

The respondents were in agreement about what they would do when costs exceeded contract specifications (44% would absorb costs). In situations where consultees were not responding to the consultants' efforts, 49% said they would try to change the situation. There was less agreement when the actual contract costs were significantly lower than negotiated fees and where the emergent situations were inconsistent with the consultants' beliefs.

"...a market needs to be created and nurses need to position themselves to provide these services. Consultation is one way of accomplishing this goal."

Professional codes appeared to guide consultants in their ethical decision making. In three of the four hypothetical cases presented, respondents selected professional codes as the rationale for their choices. There was little agreement in the reasoning about the choice of behaviors when the costs of the contract were less than those projected.

It was anticipated that the ethical issues presented in the survey would stimulate comments. For the most part, however, respondents were brief in discussing their business ethics. Perhaps the lack of response should have been expected. There is little in the literature on ethics in consultation. Gallesich (1982), one of the few to discuss this topic, makes a strong argument for the development of a code of ethics in consultation. However, in reviewing the current codes or rules of behavior that were available from five professional organizations, Gallesich (1982) found a remarkable lack of uniformity among them. It appears that the codes were designed to protect consultants from each other rather than to safeguard clients.

Beliefs about consultation

The final section of the survey evoked responses about six belief statements about consultation. The responses ranged on a five-point scale from "strongly agree" to "strongly disagree." The statements and responses are presented in Table 5.

Nurse consultants agree about the importance of fulfilling contracts and satisfying clients' interests. The high agreement by the respondents to contractual and client obligation affirms a sense of loyalty and responsibility.

Seventy percent of the respondents did not believe that nurse consultants charged enough for their services. This observation may reflect diminished self-image or the relative novelty of entrepreneurial practice. It may also explain some of the ethical dilemmas revealed in the consultants' responses to questions about over- or undercharging in contract negotiation. This finding also confirms the writer's experience that new consultants find it difficult to set fees that are appropriate, just, and competitive. One of the respondents explained that:

> One of the biggest problems has been in expanding my marketing skills. Having been trained and working as a nurse in a traditional setting for 17+ years this was and continues to be my #1 problem and concern. Consultation takes a different mind set and skills from what I'd been taught. How does a nurse who has been told she's worth $10 an hour for many years feel justified in charging $50+ an hour.

The ability to place monetary worth on work as an independent practitioner requires a positive sense of self and a belief that clinical knowledge and skills are valuable in today's health marketplace.

Discussion

Data from this survey support Gallesich's (1982) position that for-

mal education and degree preparation for consultants is important. Gallesich's (1982) educational program provides the business base needed to manage consultation practices and requires a 2-year internship. However, it may be a while before the curriculum envisioned by Gallesich becomes normative in schools of nursing. Courses in marketing, financial management, business law and the experience of working in nurse-run businesses have not characterized requirements for nursing degrees. In the interim, many consultants expressed a need for a link between consultants in order to update their knowledge and skills and offset the professional isolation of independent practice. The development of a strong consultation network would also provide a valuable resource for budding consultants. The current network, the Nurse Consultants' Association, has a membership of over 150. However, members must demonstrate that 60% of their current in-

Table 1. *Family status and education history*

Marital status	N	(%)
Married	179	67
Widowed	6	2
Divorced	38	14
Separated	5	1
Never married	42	16
Children		
None	127	48
Under 18 yr	143	52
Basic education*		
Associate	15	6
Diploma	109	42
Baccalaureate	136	52
Highest degree*		
Associate	4	2
Baccalaureate	21	8
Master's	161	62
Doctorate	74	28

* Ten subjects did not identify education.

Table 2. *Fee structure for hourly and per diem rates*

Hourly Fee ($)	N	(%)	**Daily Fee ($)**	N	(%)
Less than 35.00	24	8	100–249.99	24	9
35.00–49.99	42	15	250–499.99	109	41
50.00–74.99	90	37	500–749.99	60	22
75.00–99.99	29	11	750–999.99	16	6
100.00–124.99	25	9	1,000–1,999.99	8	3
125.00–150.00	10	3	2,000–3,999.99	1	0
Other	32	11	Other	25	9
No Response	18	6	No Response	27	10

Table 3. *Total yearly income for consultation*

Range ($)	N	(%)
500–999	21	8
1,000–4,999	47	17
5,000–9,999	35	13
10,000–19,999	33	12
20,000–29,999	20	7
30,000–39,999	34	13
40,000–49,999	12	4
50,000–59,999	11	4
60,000–69,999	6	2
Income not reported	51	19

come or 60% of their employment time is related to consultation efforts (Profiles, 1985). This criterion excludes most part-time consultants. It also disenfranchises most neophyte consultants, the group that needs the most support.

Data reported in this article have relevance for clinical specialists interested in scanning the environment before reorienting their careers. Before any such reorientation, clinical specialists must ask the following questions:

- Do I have the desire to be a consultant?
- What kind of preparation do I need?
- What kind of practice suits me and my family?
- Can I manage additional commitments and responsibilities?
- What kind of fees do I set?
- How do I get started?
- Would I like to practice on a full- or part-time basis?
- If part-time, can I negotiate a change of hours and responsibilities in my current position?
- Will my moving into this entrepreneurial world advance and improve professional nursing care?

Clinical specialists have a wealth of knowledge and experience and have the potential to improve the welfare of patients and their families, but before this can happen a market needs to be created and nurses need to position themselves to provide these services. Consultation is one way of accomplishing this goal.

Table 4. *Ethical problems in consultation*

Behavioral Response	Costs Exceeding Contract (%)	Costs Under Contract (%)	Situation Inconsistent with Beliefs (%)	Consultee Not Responding (%)
Absorb the cost	44			
Negotiate Higher fee	5			
Negotiate decreased work	2			
Negotiate fee and expected work	16	11		
Revise work output and say nothing	1			
Other solution	10	10	17	18
Do nothing		29		
Negotiate lower fee		6		
Negotiate increased work		6		
Withdraw from contract			16	10
Change situation			31	49
Accept situation			9	7
No response	22	38	27	16
Reason for Response				
Professional	67	23	43	62
Moral	17	12	19	5
Practical	8	10	4	9
Financial	6	10	1	2
Other	2	45	33	22

Table 5. *Belief statements about consultation in nursing*

Nurse consultants are:	Agree (%)	Uncertain (%)	Disagree (%)
Concerned about serving the needs of clients	93	3	4
Concerned about fulfilling contracts with clients	92	6	2
Generally prepared for the work they do	64	17	19
Respected for their contribution to development and advancement of nursing by other nurses	49	22	29
Perceived by other nurses to be too concerned with money	29	28	43
Generally charge enough for their services when compared with other consultants	14	16	70

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